

## **SCALING UP THE WARMI PROJECT: LESSONS LEARNED**

### **Mobilizing Bolivian Communities Around Reproductive Health**

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## **I. INTRODUCTION**

Bolivia's maternal, perinatal and neonatal mortality rates are higher than in any other country in the Western Hemisphere except Haiti. Bolivia's National Institute of Statistics (INE/ENDSA) estimates a national maternal mortality ratio of 390 per 100,000 live births (1994) and an infant mortality rate of 64.6 per 1,000 live births (1998). Mortality rates in some rural areas of Bolivia have been estimated to be two to three times higher than the national rates.

The *Warmi Project* was developed by Save the Children/Bolivia under the USAID-funded MotherCare project to demonstrate what could be done to reduce maternal and perinatal mortality at the community level in isolated rural areas with limited access to health services. The pilot project was carried out from 1990 to 1993 in 50 communities in Inquisivi Province. A gender sensitive participatory methodology, now known as the "Community Action Cycle", was developed to work with women's groups and other community members to improve maternal and perinatal health in their communities. The Community Action Cycle consists of four phases: "Autodiagnosis" (problem identification and prioritization), "Planning Together", "Implementation" and "Participatory Evaluation". The project achieved many noteworthy results including a reduction in perinatal mortality of nearly 50% and improved practices related to prenatal care, breastfeeding, immunization and other behaviors. In addition, women increased their participation in the community planning and decision-making processes and commented on the fact that they had never spoken to one another about these types of problems before.

The Warmi Project and methodology have evolved considerably since national scale activities were initiated in 1994. Implementing agencies include two bilateral agencies, 8 PVOs and NGOs that are members of the PVO umbrella group, PROCOSI, and government health services in selected districts. From 1995 through 1997, SC staff were based in four Bolivian cities from which they provided technical assistance to the other implementing agencies. With additional field experience the methodology has continued to become more efficient. The project is now reaching approximately 200,000 women in more than 500 rural communities in all departments of Bolivia. For the first time in their lives, thousands of women have analyzed their reproductive health, prioritized problems, and have become pro-active participants in creating better lives for themselves and their families.

The great challenge for successful community-based demonstration projects is to expand the reach of these programs to cover a much larger population without compromising the high quality of implementation necessary to achieve similar results on this larger scale. This paper describes many lessons that have been learned thus far from "scaling-up" the Warmi Project.

## **II. RESULTS**

The results of the three year implementation of the National Warmi Project are:

The WARMI methodology has reached 513 communities of the following departments, Santa Cruz, Cochabamba, Beni, Chuquisaca, Potosí, Tarija, Oruro and La Paz ( 8 of the 9 Departments in Bolivia), in

29 Health Districts. The methodology is estimated to have benefited over 200,000 women and their families. This large outreach was achieved through the efforts of seven NGO members of PROCOSI, a PVO/NGO umbrella network for organizations working in health in Bolivia. Save the Children/Bolivia provided technical assistance and training to these NGOs so that they would be able to replicate/adapt the WARMI methodology for use in their project sites. SC/B also provided technical assistance and training to two bilateral agencies including the Child and Community Health Project (CCH) supported by USAID and Health Strengthening Project (PSF-Proyecto de Fortalecimiento en Salud) supported by the Inter-American Development Bank (IDB) and the GTZ.

Of the 513 communities implementing the WARMI methodology at the national level, 289 communities worked with the NGO partners and 278 communities worked with the National Secretary of Health staff. The bilateral partners, PSF and CCH, also participated in the Warmi Project implementation.

SC/B trained 180 technicians from the National Secretary of Health and 70 technicians from PROCOSI in the four phases of the Warmi “Community Action Cycle” methodology; a total of 250 trained Warmi technicians nationally.

Currently, 170 of the trained technicians are using the methodology. Most of the ten trained technicians who have abandoned the process were from the National Secretary of Health. These technicians were either rotated out of Warmi areas or discharged.

Nationwide, 445 Warmi women's groups were organized. Through the identification and prioritization of their health problems, women from these organizations began to mobilize their communities. In all cases, the Warmi methodology helped to increase women's participation in the community. During this process, women's group members develop not only their communication skills-- they also learn how to plan interventions and negotiate with other community organizations to improve health conditions.

One of the recommendations from the National Secretary of Health during the National Project's first year evaluation was to include the community action plans that emerge from the implementation of the Warmi Methodology in the Annual Plan of the Municipal Governments (POAS). This would actively encourage sustainability and support for the methodology and broad participation of community members in the municipal planning process. This has already begun in several communities. To date, approximately 15% of the Warmi project communities' plans have been included in the municipal governments' annual plans. Many of the remaining communities are aware of, and working toward, this project objective.

Finally, the goal of the National Warmi Project was not only to conclude the Community Action Cycle in all of the communities that initiated it, but that each health District would develop the capacity to implement the Warmi Project methodology on its own. The National Warmi Project aimed to create the necessary structure, technical capacity and resources and resources in each participating institution to achieve this goal. In this effort, SC/B has been successful. While USAID funding for SC/B's technical assistance and training component of the project has ended, the methodology continues nationwide through the participating partner agencies.

### **III. “SCALING-UP” STRATEGIES**

Save the Children/Bolivia employed many strategies to “scale-up” the Warmi Project to improve maternal and neonatal health nationwide, especially in rural areas of Bolivia, including:

- Develop, implement and document a successful demonstration project;
- Disseminate project methods and results;
- Advocate to build consensus and influence policy;
- Mobilize resources;
- Define organizational structure and philosophy of the national project;
- Establish agreements with partners (MOH and NGOs);

- Provide training and technical assistance;
- Coordinating activities with partner agencies;
- Develop and use monitoring and evaluation systems; and,
- Sustain health improvements and use of project methodology in the future.

This section briefly describes each of the above strategies. The following section describes “lessons learned” through the “scaling-up” process.

### **Develop, Implement and Document a Successful Demonstration Project**

The Warmi Project was designed to serve as a pilot project that, if successful, could be expanded to many communities in similar settings. When developing the initial project proposal, SC/Bolivia and JSI/MotherCare staff looked for possible avenues for future replication of the project and identified members of “PROCOSI”, a network of PVOs and NGOs working in child survival in Bolivia, as potential partners. The Ministry of Health was also identified as an important partner.

Selected PROCOSI members and MOH staff were invited to participate in the demonstration project’s mid-term and final evaluations. All PROCOSI members were invited to attend presentations of the results of the mid-term and final evaluations. SC/Bolivia was open to suggestions and comments by participants in these events. The PROCOSI members’ active participation helped to establish a base upon which to have a more involved discussion of the project and its potential replication or adaptation by PROCOSI members in the future.

During implementation, the demonstration project staff carefully documented baseline indicators, field work and results. SC/B field staff maintained a “Women’s Health Roster” for every participating community to track each woman’s reproductive health status and practices such as use of prenatal care, use of trained birth attendants and/or clean birth kits, immediate breastfeeding, tetanus toxoid vaccination status and iron supplementation, etc. SC/B field staff kept notebooks that documented what happened during each step of the community action cycle in every community. The documentation was used by field staff during their monthly “quality circle” meetings at the zonal level where they discussed which strategies were and were not successful, and where they planned activities for the next month. Documentation was also used at quarterly evaluation and planning meetings that were held with SC/B senior program staff in the zone to monitor progress and plan future action. Ultimately, the documentation also served to provide information to others outside of SC/B who were interested in replicating or adapting the Warmi methodology.

Project results were obtained through a final evaluation (pre-post retrospective case control study, qualitative/participatory evaluation with community representatives and groups of women, men, local authorities, health service providers, etc. and a review of the Women’s Health Rosters and SC/B birth/death registers based on family census data and ongoing community and SC/B reporting).

The results of the demonstration project included positive changes in maternal and neonatal health indicators, increased women’s participation in community decision-making and led to programs that improved women’s literacy and numeracy, women’s access to credit and other opportunities. Men began to appreciate and to value what women and women’s organizations could contribute to their communities.

### **Disseminate Project Methods and Results**

The participatory methodology that was developed by the project was presented in a manual entitled, “The Warmi Project: A Participatory Approach to Improve Maternal and Neonatal Health”. Two Working Papers were produced for the MotherCare Working Paper Series detailing the project’s experience with the “Community Action Cycle” and a 17 minute video was produced that summarized the project methodology and results. These products were used to disseminate the project process and results to government health professionals, PROCOSI members, donor agencies and others interested in the experience.

Upon completion of the final evaluation, SC/B presented the results to PROCOSI members, government health professionals and donors. A formal presentation of the Warmi Project video was held for over 100 policy makers and health professionals in La Paz.

### **Advocate to Build Consensus and Influence Policy**

Following the initial dissemination phase, SC/B and USAID staff made visits to each PROCOSI member organization individually to speak with Directors and Health Program Advisors to determine whether they were interested in using the Warmi Project methodology in their project areas. Some of these visits were followed by additional presentations for groups of program staff to brief them on the methodology and results. When it was determined that there was sufficient interest to merit developing a project proposal to expand the Warmi methodology and other reproductive health activities, PROCOSI members met again as a group several times to discuss project goals and objectives and develop a logical framework for the project.

Opportunely, at the national level, a new administration dedicated to decentralization had begun to explore ways to increase popular participation at the community and municipal levels. The Warmi Project methodology and philosophy were consistent with the new administration's vision. SC/B was invited to participate on the national commission to develop the maternal and reproductive health component of the national health plan to represent a community-based perspective. The Warmi Project methodology was then included in the national health plan ("Plan Vida") as an approach to working with communities to improve maternal and neonatal health. Several policies were introduced into the plan as a result of Warmi's field experience including recognition of community-based midwives as a part of the District health referral network. The plan validated the need to make family planning services available in rural areas and created the opportunity for many other improvements.

In 1994-95, the national government introduced and began to implement the "Law of Popular Participation". The new law decentralized decision-making about local development projects and local services to the municipal level. Budget resources, which had until then been allocated by the centralized national level, were now divided and distributed to the municipalities based on a flat per capita rate. This profoundly affected communities' abilities to make positive changes (or negative ones) using local resources. The potential to improve health through the use of local resources was increased, but could be realized only if communities recognized and prioritized the need to allocate their resources for this purpose. The Warmi Project methodology helped to raise community members' awareness of health issues and the action planning phase of the Community Action Cycle became even more relevant. (Interestingly, government officials who were developing the Law of Popular Participation discussed the Warmi Project experience when they reviewed Bolivian examples of community participation and planning.)

The National Warmi Project was launched in 1995 when potential members of the project team attended a workshop in which the "Community Action Cycle" methodology was shared and demonstrated. The workshop was held in Inquisivi so that workshop participants from the various potential partner organizations could experience the methodology in the field. The National Warmi Project incorporated those who attended the workshop who were interested in participating. All participation in the National Warmi Project was on a voluntary basis.

As mentioned earlier in the "Results" section, municipalities have begun to incorporate the action plans that resulted from the "Planning Together" sessions into the Municipal Government Annual Plans.

### **Define Organizational Structure of the National Project**

The national project team consisted of five Save the Children/Bolivia field office staff, five Ministry of Health staff and one representative from each participating NGO or bilateral agency as follows:

National level : SC Project Coordinator - MOH National Coordinator  
Secretariat of PROCOSI

Regional level: Regional SC Trainers  
MOH Regional Coordinators  
NGO Regional Coordinators  
Bilateral Regional Coordinators (CCH and PSF)

District level: District Director (MOH)  
NGO implementing personnel  
MOH implementing personnel (primarily auxiliary nurses)

Community level: Women's Group President and other officers  
Local leaders (Mayors, other municipal government officials, etc.)  
Community members

The National Warmi Project Coordinators (SC/B and MOH) oversaw all project implementation and played an important role in bringing project partners together to plan, discuss strategies, monitor overall project progress and coordinate data collection. They provided technical assistance to the regional teams as needed.

SC/B staff worked with MOH counterparts at the regional level and most were housed in the MOH offices. This led to good coordination of activities and reinforced teamwork.

Training for all implementing partners was organized by SC/B using a cascade approach. The SC/B Regional trainer in each region carried out training in each phase of the project methodology that was attended by Warmi Project Coordinators from the implementing agencies. These Coordinators would return to their field sites and train their project teams. Often, SC/B staff would assist with these trainings. To follow-up, SC/B staff visited field sites to provide technical assistance and determine how training could be improved.

#### **Mobilize Resources**

USAID invested approximately \$300,000 in the development of the demonstration project in Inquisivi over a three year period. This included the costs of project design and development, all field implementation, materials, technical assistance, monitoring and evaluation and documentation. To reach rural areas on a national scale, more resources were required.

Mobilizing resources for the National Warmi Project was a challenging and complex task that required months of consensus building, negotiation, proposal development and review, and patience. The USAID/Bolivia Mission provided funding to PROCOSI (approximately \$4 million over a three year period) for its members to carry out reproductive health activities including Warmi Project replication/adaptation. The USAID-funded MotherCare Project provided approximately \$360,000 to SC/B over a three year period to provide coordination, materials development, technical assistance and training for all implementing partners. The USAID-funded Child and Community Health Project (CCH) and the Inter-American Development Bank PSF Project provided its own funding to replicate the Warmi methodology in the ten districts in which they worked.

#### **Provide Training and Technical Assistance**

Project team partners were trained intensively in the philosophy and application of the methodology and in adult learning principles and techniques. The members of the National Warmi Project SC/Bolivia technical assistance team were involved in the demonstration phase of the project in Inquisivi which provided them with invaluable field experience.

SC staff held participatory workshops in each region throughout the country to train NGO and district MOH facilitators in each phase of the Community Action Cycle methodology. These workshops were followed-up by visits from SC/B staff to field sites to assist partners with their own workshops and field work with communities. SC/B's supportive role and openness to being flexible in the adaptation of the methodology to local realities helped to increase their partners' ownership of the methodology.

#### **Establish Agreements and Coordinate with Partners (MOH and NGOs)**

SC/Bolivia developed written agreements with each participating organization and with the Ministry of Health at the national, regional and district levels. The agreements clearly established the roles, responsibilities and contributions of each party as well as the desired project results and products.

Implementing partners included the Ministry of Health, the Child and Community Health Project (CCH), the Health Strengthening Project (PSF) funded by the IDB with technical assistance from the GTZ, and NGOs. Eight of the 24 members of PROCOSI, a network of NGOs working in health, participated in the replication of the WARMI methodology including:

- Association of Health Programs in Rural Areas (APSAR)
- Association of Health Promoters in Rural Areas (APROSAR)
- CARE
- Freedom From Hunger (FFH)
- Plan International (PI)
- Project Concern International (PCI)
- Rural Andean Health Project (CSRA)
- Save the Children (SC).

From the beginning of the project, the National Health Secretariat played a very important role in the planning and monitoring of project activities. As anticipated, the Health Districts, the Regional Directors' Offices and Regional District Offices coordinated project implementation at the regional and local levels.

Project implementation was hindered by several factors in some of the districts in Oruro and Potosí. A delay in the disbursement of funds from PSF (a partner agency) to support the implementation of training workshops and monitoring activities in project communities. The relocation of trained personnel to other areas where the project was not implementing the WARMI methodology meant that new personnel needed to be trained or the methodology would not be implemented in that area. Thus, keeping trained personnel on the project can be problematic, particularly when there is constant change of staff which is not uncommon when working with government health institutions or unstable partner organizations.

The partnership between SC/B and CCH in Santa Cruz and La Paz proceeded very well. Currently, each Regional Office is informed about the achievements obtained through the Warmi methodology in each district.

### **Monitoring and Evaluation**

Throughout the project, SC/B coordinated monitoring and evaluation in each of the participating Health Districts through the following activities:

- ◆ Regular site visits to monitor progress and provide technical assistance
- ◆ Monthly evaluation and planning meetings in each District
- ◆ National Evaluation Workshop (1 per year)
- ◆ Mid-Term Evaluation
- ◆ Mid-Term Regional Evaluations (7 per year, 1 per region)
- ◆ Final Evaluation

During implementation of the National Warmi Project, SC/B staff visited the Districts and selected communities to closely monitor the quality of the implementation process.

Leadership in project coordination and implementation was assumed by all the members of PROCOSI and the MOH. Joint leadership resulted in well planned Warmi activities, and served as an experiential learning process to strengthen organizational capacity. SC/B is certain that this process has increased the likelihood that the project will be sustained, particularly by CARE in Potosí and Rural Andean Health in La Paz.

At the first National Evaluation Workshop held in March 1996, the participants defined and decided upon impact indicators which are now included in the Bolivian National Information System (SNIS). These indicators are:

- ◆ Perinatal Mortality
- ◆ No. of pregnant women who had at least one prenatal visit

- ◆ No. of pregnant women who had at least to doses of TT
- ◆ No. of deliveries attended by trained community personnel
- ◆ No. of deliveries attended by health personnel (doctors, nurses, etc.)
- ◆ No. of women of fertile age that use contraceptive methods
- ◆ No. of pregnant women in high risk referred to the health system.

The results of the project have not yet been measured as the majority of communities have only recently concluded the Community Action Cycle. An impact study will be carried out at the end of 1998.

#### **Sustain health improvements and use of project methodology in the future**

It is too early to judge whether health improvements that have been achieved as a result of the National Warmi Project will be sustained long-term. The Inquisivi demonstration project experience indicates that positive trends are likely to continue, providing conditions in Bolivia remain relatively stable.

There are several indications that the methodology will continue to be used by government health staff and NGOs, at least for the next few years. As mentioned earlier, several PVO partners decided to use their own resources to continue to receive SC/B technical assistance when MotherCare's financial support of this component ended in December 1997. The Warmi methodology is now contributing to the development of municipal annual plans. Ministry of Health staff continue to use the methodology in their work with communities, and, as many of these workers are at the auxiliary nurse level, they do not rotate out of their communities as rapidly as doctors do. Importantly, when the new government administration assumed power, the new National Secretary of Health staff maintained the project through the transition.

Current project implementors have recommended that the methodology be included in medical and public health university courses. In Potosi and Sucre, university students have participated in the Warmi Project as part of their course field work. In Santa Cruz, medical students were oriented in the Warmi methodology before beginning their mandatory rural service. In fact, in the United States, the Warmi Project experience has been introduced in graduate classes at Johns Hopkins University, George Washington University, Yale University, University of Arizona and other schools. In Peru, Warmi methodology is taught in the University in Lima. As a result of these classes, some graduate students have gone on to adopt various aspects of the methodology and approach in their field work.

Internationally, the Warmi Project experience has been presented at a number of conferences including a WHO meeting in Geneva attended by African health policy makers and other health professionals. In Peru, a national reproductive health project, ReproSalud, was designed based on the Warmi methodology. ReproSalud is now finishing its second year of implementation. Currently, Plan International is introducing the Warmi methodology in Ecuador as part of the First Ladies' of Latin America Initiative to Reduce Maternal Mortality. There appears to be great interest in applying the methodology in other settings. It is important to stress that the Warmi methodology's application in other settings may require modification and should not be replicated on a large scale in a new setting until program implementors are convinced that the process is appropriate in the new cultural context.

#### **IV. LESSONS LEARNED**

- Participatory processes require time to implement. In scaling-up Warmi, the project methodology in the community was participatory as were the coordination, budgeting and administration in the larger initiative. Accommodating timing between various organizations working collectively with common objectives while respecting each agency's independence demands more time than was anticipated to achieve project sustainability, establish measurable impact and utilize participatory processes. A three-year project time frame is not realistic.
- Communities lose interest in the Warmi process if long periods of time pass without follow-up by the trainers, particularly during the initial Community Action Cycles. The implementing organization loses credibility in the eyes of the community if follow-up is not punctual. Delayed funding

disbursements by bilateral partners sometimes created gaps in training and implementation of the methodology. When this happens, the project risks losing the participation and interest of the leaders and women organized into groups in the process and momentum is lost.

- Educational processes are long and complex, especially when they aim toward a critical understanding of one's reality and self-determined change (it is probably simpler to disseminate knowledge about diagnosing illness, but is less long-lasting). Warmi essentially works to awaken critical consciousness and awareness of one's reality and the results of this process cannot be measured in quantitative terms. Evaluation should also include ways to show "empowerment" of women and communities, measuring their capacity to exercise their right to participate and propose actions to solve their problems.
- Before beginning to implement the Warmi methodology, it is important to carefully select and understand communities, paying particular attention to socio-cultural factors. For example, in communities where women normally do not participate in decision-making in the community or in their families, when one begins to work here one must solicit the approval of male leaders and husbands first to try to prevent resistance and encourage men's participation. Men must feel comfortable that they too can participate if the Warmi process is to be successful.
- The Warmi methodology creates demand for information and immediate services. The institutions implementing the Warmi Project and health providers serving Warmi Project areas should plan for this increase in demand. Communities generally request information on such themes as the importance of pre- and post-natal exams, sexually transmitted diseases and infections and others. To respond to this demand, didactic materials need to be obtained and/or developed and health personnel need to be well trained in all aspects of reproductive health services. Service providers should ensure that they have sufficient commodities and supplies on hand to meet the increased demand for family planning and other reproductive health services. The National Warmi Project experience has been that health district services were not prepared for the increased demand in part due to shortages of contraceptive supplies and in part due to lack of clinical training in contraceptive methods. This led to an increased demand by service providers for training and adequate supplies. Specifically, in districts in Tarija, La Paz, Sucre and other areas, providers obtained the necessary supplies from the regional warehouses of MOH. They also scheduled training for those providers who needed it, in some cases very rapidly.
- The Warmi methodology generates reflection and analysis not only about reproductive health problems, but also about such themes as human sexuality, self-esteem, family violence, human rights and others. It also opens communication between women, and between women and their husbands, and increases women's participation in community affairs. These results were consistently achieved by the National Warmi Project regardless of the implementing agency.
- Several important achievements support the likelihood that the project and the Warmi methodology will be sustained including: community leaders have been trained in, and are using, the Warmi methodology; the Warmi process was articulated in the national health plan; and, the fact that NGOs are now using their own resources to pay for technical assistance and to implement the methodology in new project sites.
- Interinstitutional coordination was key to the success of the scaling-up effort. The coordination with the Ministry of Health was not just at the executive level, but negotiation and action took place at the regional, district, sector and area levels as well.
- When new methods are introduced, there may be initial resistance but this can be overcome if the methods are effective. For example, government auxiliary nurses initially saw the Warmi methodology as one more thing they had to do. This changed over time and most now enjoy this aspect of their job. The constant assistance by SC/B staff was critical to the successful implementation of the project. In areas where SC/B was not able to assist project teams due to geographic isolation, field workers did not complete the process or the process was delayed.

- The staffing of the project was well designed. The National Coordinator of the Warmi Project managed and coordinated the activities implemented by the Regional Trainers. Few technical staff meant low direct and indirect costs and required intensive reliance on the participating organizations to implement, yet provided national coverage in Warmi technical matters.
- The technical personnel in charge of coordinating the Warmi Project for partner agencies should possess the following characteristics: high level of skill in non-formal education methodologies, speak the regional language, exceptional interpersonal skills so that they are capable of obtaining the acceptance of the communities and commitment to stay with the project for at least two years.
- The original Warmi methodology was very time intensive, particularly when women's groups did not exist prior to the project and participants had not had experience with group processes such as priority setting and planning. These processes take time, and women's time is valuable. Community participants must be able to quickly measure the impact that their participation has had or they will cease to participate. The Warmi methodology has responded to this need and has reduced the total time required to implement the entire process. Originally, a community action cycle would require eight months to a year to complete. The revised methodology, which will be detailed in the Second Manual for Warmi Implementors, has cut down the time required to complete the first cycle to approximately six months. Subsequent cycles are often shorter and a community would need to complete four or five cycles before its members could then internalize and apply the process on their own.
- The expansion of the Warmi methodology to "ReproSalud", a national project in Peru, demonstrated that participatory, community-based methods can spread to other countries as well. After two years of implementation, ReproSalud is still relatively young but several lessons can be learned from its work so far. The ReproSalud project staff based their project design on the Warmi methodology after they participated in a briefing by SC/B staff. While ReproSalud improved on some steps in the methodology, some very important aspects of the approach were not included such as the participation of men, local leaders and decision-makers in the "Planning Together" phase. This change had a detrimental effect on the project's acceptance and integration into some communities where it has been implemented leading to keeping women relatively isolated from community decision-making. It is important to be flexible in adapting methodologies to meet the needs of partner organizations, but to help ensure that similar successful results are achieved, the basic principles and approaches that have had success should be maintained. Organizations will learn what works and does not work through their own experience in the field, as the ReproSalud project has learned that it now needs to include men. The benefit of having on-the-ground technical assistance from organizations that have successfully implemented the methodology is that these lessons have often already been learned and could have been shared with new partners. This also points to the need for very detailed documentation, not only of the methods used, but the rationale behind them.

## V. CONCLUSION

The expansion of the Warmi demonstration project to a national program offers a wealth of experience in how participatory approaches can be brought to a national scale through flexibility, interinstitutional coordination and establishing common goals.

"Scaling-up" is an evolutionary process. While an organization cannot guarantee that every successful demonstration project will go to scale, there are many things that an organization can do to enhance the likelihood that a successful demonstration or pilot project will be replicated or adapted to reach more people in need. Nevertheless, there are always positive and negative conditions which are beyond an organization's control. An insightful analysis and understanding of the external environment (health problems, government and donor priorities, etc.) and good timing to take advantage of potential support are critical to success. The willingness and ability to be flexible, negotiate and be patient are essential.

If a methodology is effective and is clearly and systematically shared with a wide audience, it is likely that at least a few organizations will try it out and continue to use it if they are successful. Participation in a “scaling-up” effort must be voluntary. To help other organizations replicate or adapt promising methodologies, careful documentation and step-by-step descriptions of what has been done, how it has been done and why it has been done this way are invaluable. Technical assistance and training that are sensitive to organizational strengths, weaknesses, structure and philosophy, in addition to being technically sound, are also strongly recommended.

The following table, “Eight Steps to ‘Scaling-Up’” presents a summary of the major steps that the Warmi Project followed.

<b>Eight Steps to “Scaling-Up”</b>	
1.	Establish that the technical intervention, methodology or approach that is being considered for scaling up leads to desired results through carefully evaluated and documented research.
2.	Assess possibilities for scaling up (need, available resources, political will, potential partners, etc. and potential barriers to scaling up (opponents and their arguments, policies, etc.).
3.	Build consensus for scaling up among decision makers, implementors and leaders of those who participate in the program/ use the intervention through meetings, presentations, field visits, etc. with key individuals and groups.
4.	Ensure that policies are supportive and that resources will be available.
5.	Develop plans/proposals with decision makers and implementors on the organizational structure and relationships of the scale up, activities, management, monitoring and evaluation, training and technical assistance, etc. Program designs or interventions should be simplified as much as possible and should be accessible in “user friendly” language.
6.	Be prepared to solicit many donors and negotiate many hours in order to put all pieces into place. The amount of funding needed for large scale programs is often not available through only one donor. Negotiate contracts, budgets, work plans.
7.	Prepare training and technical assistance teams and materials to work at regional or other level depending on organizational structure. Be flexible and adapt to meet local conditions whenever possible without losing essential elements of quality.
8.	Program implementors meet regularly on local, regional and national levels to monitor progress, detect problems, develop innovative solutions/approaches, strengthen skills and build team. Ensure that representatives from those who are participating in the program (community men and women, etc.) participate in monitoring and evaluation at a minimum at the local level.
The scaling-up process requires a tremendous amount of negotiation, diplomacy, patience, flexibility, time and resources to be successful.	

We are still learning much about what is and is not working. Many challenges remain for us to truly evaluate the results of this project. While health indicators have appropriately been the primary focus of the evaluation framework, the Warmi methodology affects broader aspects of community life and community members’ skills that we have not systematically evaluated and that have important implications for sustainability of the project and continued improvements in community development including health. Women’s “empowerment”, men’s “empowerment to empower women”, problem identification and prioritization skills, planning skills and ways that communities organize to take action are just some of the areas that should be studied more extensively.

